

STATE OF MICHIGAN
IN THE SUPREME COURT

COVENANT MEDICAL CENTER,

Plaintiff/Appellee,

v.

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY, a Michigan
insurance corporation,

Defendant/Appellant.

Supreme Court Case No. 152758

Court Of Appeals Case No. 322108

Saginaw County Circuit Court
Case No. 13-020416-NF

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**DEFENDANT-APPELLANT STATE FARM MUTUAL AUTOMOBILE INSURANCE
COMPANY'S REPLY IN SUPPORT OF ITS APPLICATION FOR LEAVE TO APPEAL**

ORAL ARGUMENT REQUESTED

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I. COVENANT'S RESPONSE HIGHLIGHTS THE SIGNIFICANCE OF THIS CASE TO THE STATE'S JURISPRUDENCE

Covenant Medical Center ("Covenant") miscasts State Farm's arguments as "alarmist rhetoric" (Brief Opposing Application ("Opp"), p. 9) and erroneously claims there are easy ways to avoid the impact of the Court of Appeals' decision and continue to meaningfully settle No-Fault claims. Yet Covenant ignores both the impact of their proposed alternatives on injured parties, insurers, and the judiciary; and practical realities. The impracticability of Covenant's "options" underscores the significance of this case and the need for review by this Court.¹ If, when, and how No-Fault claims – of which there are many – can be settled is undoubtedly a legal principle of major significance to the state's jurisprudence.

Covenant first incorrectly claims apportionment proceedings are not required under the Court of Appeals' decision,² and then claims that there are other options, including: (1) settling with the insured before receiving written notice of any other claim; (2) carving providers' claims out of a settlement; (3) insured's counsel seeking authority from providers to negotiate their claims; or (4) negotiating a "global settlement" with the insured and all providers. (Opp, pp. 2, 9, 18, 20). Practically speaking, these "options" are not viable, and legally speaking, they fail to recognize the insured's ownership of the benefits claim, and are irrelevant to the fact that the Court of Appeals misinterpreted Section 3112.

¹ An internet search of *Covenant v State Farm* pulls up numerous articles, blogs, and website discussions, further confirming this case's significance. Counsel for Covenant is quoted in the *Michigan Lawyers' Weekly* (attached as Ex. A) as calling this "a really big case for medical providers", and stating that the Court of Appeals' decision has prompted "a lot of chatter".

² The Court of Appeals did indeed state that apportionment orders are mandatory when the insurer has received written notice of the claim of another, holding that, in such case, "the statute *requires* that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated". (COA Opinion, p 3 (emphasis added)). As noted in the Application, this interpretation is not supported by MCL 500.3112's plain language.

Covenant's first option, "settle before notice of another claim", is nonexistent in light of the Court of Appeals' implicit finding that a medical bill constitutes notification in writing "of the claim of some other person" under Section 3112.³ Between the common practice of providers sending bills directly to insurers, and of insureds providing copies of medical and other bills for recoverable PIP costs to their insurer, an insurer has virtually always "been notified in writing of the claim of some other person", as that phrase was interpreted by the Court of Appeals and thus, a circuit court apportionment order⁴ is now virtually always needed for full resolution of a claim.⁵

The second option, "carving out the provider's claim", is also not viable and ignores the binding precedent that PIP benefits belong to the injured person. *See, e.g., Hatcher v State Farm Mut Auto Ins Co*, 269 Mich App 596, 600; 712 NW2d 744 (2005); *In re Hales Estate*, 182 Mich

³ Covenant argued below that "notice" under Section 3112 should be the same as "notice" under MCL 500.3145. (Covenant's Brief on Appeal, p 5). The Court of Appeals recently recognized that medical bills alone may not satisfy the "notice" requirements of MCL 500.3145, even if a bill is "sufficient in content", because the notice must also fulfill the purposes of the statute. *Perkovic v Zurich American Ins Co*, ___ Mich App ___, ___ NW2d ___ (2015) (attached as Ex. B). Because a medical bill sent directly to the insurer is to obtain payment *for the benefit of the injured person*, not to give notice of the "claim" of the provider, for Section 3112 purposes, simply providing a bill cannot reasonably be viewed as sufficient to put an insurer on notice of the claim of "some other person". *See also Heikkinen v Aetna Cas & Sur Co*, 124 Mich App 459, 461; 335 NW2d 3 (1981) ("Notice encompasses something more than words typed on a piece of paper.")

⁴ Covenant argues State Farm waived the argument that the Court of Appeals' apportionment requirement is improper by not raising it below. (Response, p. 8). There was no waiver; that argument could not have been made below because State Farm prevailed in the Circuit Court and the Court of Appeals had not made the apportionment requirement until it issued its decision.

⁵ Covenant fails to meaningfully address the jurisdictional issues that arise from an apportionment proceeding when there is more than one suit pending on a claim, stating they can be resolved by motions to transfer, intervene, and/or consolidate. (Opp, p. 10). State Farm is unaware of any legal basis for a transfer from district to circuit court, where there are statutory jurisdictional limits that may not be met. And what if such motions are denied? In any event, such proceedings further increase costs and delay, and burden the court system.

App 55, 58; 451 NW2d 867 (1990). Covenant repeatedly states this would only require carving out “the provider’s claim” (singular) (Opp, pp. 2, 18, 20, emphasis added), but in reality PIP claims can have anywhere from one to 40 plus providers. Also, “carving out” would essentially constitute a settlement with the injured party solely for wage loss claims (as these are the only recoverable PIP benefits that do not take the form of services rendered by another), and take away rights that belong to the injured party, that is, the right to payment of their medical bills – how many insureds would agree to a settlement excluding large parts of their claim?⁶

Covenant’s third and fourth “options” – obtaining authority “to negotiate the provider’s claim”, or the insurer contacting the provider(s) to negotiate a global settlement – assume, without basis, that providers will settle or negotiate as part of an injured party’s case.⁷ These options also ignore the insured’s right to the claim, and are contrary to both Section 3112 as interpreted by the Court of Appeals, and Covenant’s vehement claim that a party “cannot circumvent” Section 3112 “by release” or “by contract.” (Opp, pp. 2, 11, 12, 14). The Court of Appeals held that Section 3112’s apportionment provision trumped a settlement agreement that released all claims for PIP benefits. Per its decision, the apportionment provision is triggered “when there is doubt” about who should receive benefits, and/or how much, irrespective of any settlement reached by the parties. Covenant assumes this holding would *not* apply when a provider authorizes the negotiation of its claim or participates in a global settlement, but per the Court of Appeals’ decision, it *does* apply if there are disputes – or even potential disputes – about who should receive what amount of the settlement (especially possible when someone else

⁶ For the same reason it is unlikely an injured party would agree to exclude provider claims from case evaluation or mediation, as Covenant suggests. (Opp, n. 3).

⁷ A provider’s refusal to participate is certainly possible. Providers may not want to negotiate for every No-Fault patient as this would be time consuming and costly. Or they may wish to “hold out”, anticipating a higher settlement payment to resolve their own lawsuit.

negotiated the provider's claim). Covenant's belief that a global insurer-injured party-provider release, or insurer-provider release, would be conclusive, whereas an insurer-injured party release requires a subsequent Section 3112 apportionment hearing, has no basis in the Court of Appeals' decision. If apportionment is required to discharge liability any time potential doubt is raised about who or how much to pay – as the Court of Appeals wrongfully held – any release is meaningless.

Nor is there a legal basis for an insurer to treat providers as claimants with whom to negotiate separate from the injured person. Any right a provider has under the No-Fault Act, if any,⁸ is to *receive* payment “for the benefit of” the injured person. Therefore, a provider's claim is, at most, derivative of that of the injured person. To require an insurer to negotiate with providers in addition to the insured in order to fully resolve a claim grants providers rights they do not have under the applicable insurance contract, to which they are not a party.

These “options” – and indeed, the Court of Appeals' decision – are also contrary to the Court of Appeals' holding that the insured is obligated to understand what she is agreeing to when settling PIP claims, and such an agreement is binding. In *Clark v Progressive Ins Co*, 309 Mich App 387; ___ NW2d ___ (2015), the plaintiff sued Progressive for PIP benefits and agreed to resolve the claim for \$78,000 “for all benefits to date.” The insurer knew, but plaintiff's counsel was unaware, that plaintiff had incurred prior medical expenses totaling \$28,942. In support of a separate claim by the provider, plaintiff's counsel argued he would not have settled for that amount if he had been aware of the bill. The Court of Appeals rejected plaintiff's argument that Progressive was obligated to inform her counsel of the bill and reversed the trial

⁸ State Farm has filed an Application for Leave to Appeal in *Chiropractors Rehabilitation Group, PC v State Farm Mut Auto Ins Co*, ___ Mich App ___; ___ NW2d ___ (2015), arguing that providers do not have an independent right of action under the No-Fault Act.

court's ruling that the \$28,942 claim was not part of the settlement and could be separately pursued. The court stated:

Progressive...is in an adversarial position with Plaintiff and, as such, has every right to protect its interests and to expect that Court [sic] will uphold a settlement freely entered into by the parties. Progressive paid to buy its peace, not to advise Plaintiff and her lawyer on how to settle a case. Were we to accept the proposition advanced by Plaintiff, we would undermine the finality of settlements and, perhaps, place opposing counsel in the untenable and conflicted position of advising two parties: his client on how to best settle a claim, and his opponent on what claims to include in a settlement. This we cannot and will not do.

309 Mich App at 402. Here, the Court of Appeals did precisely what the *Clark* court refused to do – undermine the finality of settlements with the insured, who has the authority to fully resolve her claim.

Significantly, Covenant's "options" prejudice the one person the No-Fault Act is designed to protect: the injured party. Settlements with the insured alone have essentially now been written out of existence; instead, more parties must be involved, and more proceedings held, increasing costs and delay. If an insured does settle a wage loss claim, she could still be embroiled in litigation between the provider and insurer over such issues as coverage, reasonableness and necessity of treatment, or causation; delaying payment, increasing litigation, and burdening the judicial system and the insured, who thought the matter had been resolved.

For all of these reasons, this Court should grant leave to appeal under MCR 7.305(B)(3).

II. LIKE THE COURT OF APPEALS, COVENANT'S INTERPRETATION OF MCL 500.3112 IS CLEARLY ERRONOUS.

Covenant repeatedly argues that State Farm's goal is to cut medical providers out of the process in order to settle claims for less. (Opp, pp. 5, 9, 10, 11). This accusation is unfounded

and untrue.⁹ State Farm strives to fulfill its obligations under its contracts and the No-Fault Act. What State Farm does not want to do is make duplicative or otherwise improper payments, as that would be an irresponsible corporate act. But the Court of Appeals held that State Farm may have to pay twice on the same claim, reviving Covenant's claim even though Covenant's bills were part of State Farm's settlement with the insured.¹⁰ If this case is not reversed, State Farm will have to litigate whether it must pay over \$100,000 in No-Fault benefits even though it and its insured understood State Farm's exposure to be limited to the \$59,000 settlement and thought the claim had been resolved. More importantly for purposes of this Court, because it is published, the Court of Appeals' decision will have the same effect on numerous other insurers and insureds in the same predicament. Such an outcome is not supported by the statute, case law, or the purpose behind the No-Fault Act.

Covenant argues State Farm is wrongfully trying to circumvent Section 3112 by contract, but then argues Section 3112 *can* be circumvented, just by a different *kind* of contract. Covenant therefore recognizes that Section 3112 does not preclude discharge by release, as has been the practice for decades. As explained in the Application (pp. 14-19), the statute does not provide that the *only* way an insurer may discharge its liability to pay PIP benefits is through Section 3112. Rather, it provides one safe way for an insurer to do so. Thus the holding in *Michigan Head & Spine Institute, PC v State Farm Mutual Auto Ins Co*, 299 Mich App 442, 447; 830

⁹ Many plaintiff's lawyers would take exception with Covenant's suggestion that insurers would rather negotiate with the insureds as they have "fewer resources" than providers. (Opp, p. 9). To the contrary, accident victims often have sophisticated counsel with significant resources.

¹⁰ Covenant argues the standard indemnification language in the release proves State Farm understood providers like Covenant could bring claims against it for benefits. (Opp, p. 12). But the release simply states that if a provider makes demands against State Farm, the insured will indemnify and hold harmless State Farm. This certainly does not mean State Farm conceded such litigation would be appropriate or that this was not a complete release, as the release expressly stated it was.

NW2d 781 (2013), that “it is well established that an injured person entitled to no-fault benefits may waive that entitlement and release an insurer from payment of future benefits in exchange for a settlement.” Whether the provider bill is presented to the insurer before or after the settlement should not impact this general legal principle.

Section 3112 also does not apply because Covenant, as a provider, is not “some other person”,¹¹ and the apportionment process refers to survivor’s loss issues, not any claim by a provider. Section 3112’s use of the term “other” necessarily implies that the claim must be one distinct from that of the injured person. *See* Merriam-Webster’s Collegiate Dictionary (2004) (defining “other” as “the one or ones distinct from that or those first mentioned or implied”). It is well-settled that PIP benefits belong to the injured person. *See Hatcher, In re Hales*. The No-Fault Act created a framework by which *persons injured in automobile accidents* are entitled to certain benefits. Numerous Sections of the Act, including 3112, 3114, and 3145, discuss persons injured in accidents, and when such persons are entitled to benefits or how such benefits may be recovered; there is no reference to any type of benefits claimant other than injured persons and their survivors. This Court has stated that the goal of the Act is “to compensate...a *limited class of persons* for economic losses sustained as a result of motor vehicle accidents. Under personal protection insurance, *benefits are made payable only to injured persons or surviving dependents of the injured person.*” *Belcher v Aetna Cas & Surety Co*, 409 Mich 231, 243-44; 293 NW2d 594 (1980)(emphasis added). And numerous decisions hold that providers’ claims, to the extent they exist at all, are derivative of those of the injured person, and providers therefore “stand in the shoes of” the injured.

¹¹ Covenant claims State Farm waived its argument that a provider is not “some other person” because it admitted in the trial court that providers have a direct right of reimbursement. (Opp, p. 14). But saying a provider can be reimbursed directly is not a concession that a provider’s bill is notice of a claim of “some other person”.

This proposition was most recently reiterated in *Michigan Head & Spine Institute PC* (“MHSI”) v *State Farm Mutual Auto Ins Co*, unpublished decision of Court of Appeals, issued Jan. 21, 2016 (Docket No 324245)(attached as Ex C). The insured sued State Farm for unpaid medical bills, including those of MHSI. A jury found that State Farm did not owe the insured any more payments. The Court of Appeals upheld the dismissal of MHSI’s separate suit against State Farm as barred by *res judicata*, even though MHSI’s bills had not been presented to the jury, because they could have been, if the insured had so chosen. The court cited numerous cases, including *TCBI, PC v State Farm Mut Auto Ins Co*, 289 Mich App 39; 795 NW2d 229 (2010) and *Moody v Home Owners Ins Co*, 304 Mich App 415; 849 NW2d 31 (2014), for the proposition that “a healthcare provider seeking payment under a no-fault insurance policy stands in privity with an injured party who previously brought a lawsuit against the insurer attempting to claim benefits under the same policy” and “by seeking payment from State Farm, MHSI stands in [the insured’s] shoes.” (Ex. C, pp. 3, 4). The court concluded that “State Farm should not be faced with the costs and vexation of additional litigation, and the interests of judicial economy will be served by the application of *res judicata* to preclude MHSI’s lawsuit.” (*Id.*, p. 5). Thus, under the Court of Appeals’ logic, if an insurer settles a claim for all PIP benefits with the insured, including those of a provider whose bills the parties are aware of, and obtains a dismissal with prejudice, that does *not* bar a later suit by that provider; but a jury verdict in favor of the insurer *does*. Such a result hardly promotes judicial economy. Because, as numerous cases hold, the provider and the insured are in privity and have the same interests, there should be no difference based on how the insured’s claim is resolved, either way, the outcome should be the same.

Covenant tries to distinguish *Bahri v IDS Property Cas Ins Co*, 289 Mich App 39; 795 NW2d 229 (2010); *TCBI*, and *Moody* on the grounds that they involved fraud on the part of the insured or jurisdictional limits. (Opp, pp. 16-17). But again, Covenant cannot dispute that regardless of the different facts involved, all these cases stand for the proposition that provider claims are derivative of, and rise or fall with, the claims of the insured. As such, providers do not have claims as “some other person” – they stand in the shoes of the insured when seeking payment for medical bills. Section 3112 is therefore not invoked when provider bills are submitted to the insurer, as they are not “not[ice] in writing of the claim of some other person.”

Finally, Covenant incorrectly claims the Court of Appeals’ decision gives effect to “the entire statute.” (Opp, p. 18). A sentence-by-sentence analysis of Section 3112 proves Covenant wrong. In paying medical bills “for the benefit of” the injured person under Section 3112’s first sentence, an insurer is choosing the option of paying a third party directly in order to expedite the payment process. Just because the insurer has this option does not mean that the third party has an independent claim unrelated to the injured person. As discussed above, the second sentence provides a safe method of discharge by an insurer if it makes a good faith payment to (or for the benefit of) a person that the insurer believes is entitled to the benefit. That sentence does not create any new rights and the phrase “to or for the benefit of a person who [the insurer] believes is entitled to the benefits” clarifies its meaning: since PIP benefits belong to the injured person, he or she is the *only* person to or for whom the allowable expenses are payable.

The third sentence establishes a method the insurer can pursue if there is doubt as to the proper person to receive benefits. Such doubt only arises if there is a survivor’s loss claim involving a person not conclusively presumed to be a dependent under MCL 500.3110(1). Insurers have no “doubt” that they may pay medical bills directly, but in so doing, are paying

them on behalf of the insured. That the remaining sentences in Section 3112 specifically speak to survivor's losses buttresses the conclusion that all but the first sentence address such losses. In sum, Section 3112 does not indicate an intention to make providers "some other person" entitled to make a "claim" under the No-Fault Act such that their bills must be resolved via an apportionment proceeding and not by settlement with the insured.¹²

The Court of Appeals' interpretation is clearly erroneous, will cause material injustice, and conflicts with other decisions. This Court should grant leave under MCR 7.305(B)(5).

CONCLUSION AND REQUEST FOR RELIEF

Defendant-Appellant requests that this Court grant its Application for Leave to Appeal and reverse the Court of Appeals' opinion and reinstate the Circuit Court opinion and order.

Respectfully submitted,

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Dated: February 4, 2016

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¹² Covenant claims State Farm's position will allow a no-fault insurer to "stop a provider's claim" by paying the insured less than the amounts actually owed. (Opp, p. 16). However, the amounts owed by the insured to the provider are unaffected by the settlement. It is up to the insured, not the insurer, to pay in full or negotiate that amount down to something acceptable to both them and the provider. Covenant claims that *Miller v Citizens Ins Co*, 490 Mich 904; 804 NW2d 740 (2011) holds that a settlement between the injured person and the insurer does not extinguish "the provider's claims", apparently meaning any claims the provider may have against the insurer. (Opp, p. 14). But this Court's order only said the settlement "did not have the effect of extinguishing the [provider's] *right to collect the remainder of its bill from plaintiff*." 490 Mich at 905 (emphasis added).

INDEX TO EXHIBITS

- A. Michigan Lawyer's Weekly, Nov. 17, 2015, article.
- B. *Perkovic v Zurich American Ins Co*, __ Mich App __; __ NW2d __ (2015).
- C. *Michigan Head & Spine Institute PC ("MHSI") v State Farm Mutual Auto Ins Co*, unpublished decision of Court of Appeals, issued Jan. 21, 2016 (Docket No 324245).

CERTIFICATE OF SERVICE

On February 4, 2016 I e-filed this Reply in Support of Application For Leave To Appeal with the Michigan Supreme Court which will serve copies on all counsel of record.

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